Massachusetts Department of Mental Health

Task Force on the Restraint and Seclusion of Persons who have been Physically or Sexually Abused

Report and Recommendations

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Research findings suggest that at least half of all women and a substantial number of men treated in psychiatric settings have histories of physical or sexual abuse, or both (Carmen, Rieker, and Mills, 1984; Bryer et al., 1987; Craine et al., 1988). We assume that clients currently being treated through the Massachusetts Department of Mental Health (DMH) are no exception. Anecdotal evidence available to Task Force members confirms these statistics. Analysis of data on children and adolescents in DMH secure treatment settings suggests even higher percentages. Task Force members have reason to believe that the reported statistics may underestimate the total number of people receiving mental health services who have histories of abuse. Although JCAHO standards for 1995 mandate that possible victims of abuse and neglect are identified in community and hospital based treatment settings (MHM 1995, PE.1.15), we suspect that most DMH public and contracted treatment settings are substantially out of compliance with this requirement. (Appendix I)

For many people diagnosed with a major mental illness, the occurrence of physical and sexual abuse across the life span has served to confound treatment of their illness. These mentally ill survivors often become high users of mental health services around such issues as substance abuse, suicidality, self-injury, assaultiveness, and repeated victimization. As a consequence of inadequate assessment and inappropriate treatment, neither hospital-based nor crisis services have been able to meet the needs of these clients for more than temporary respite. Indeed, there is growing evidence that in most mental health settings, such clients are likely to be retraumatized, leaving them in a continuing cycle of trauma and response.

Retraumatization occurs through failure to recognize, understand, and respond appropriately to the survivor's symptomatology. It also occurs through the use of restraint and seclusion, the lack of physical safety in institutional settings, and fragmented and inconsistent treatment. Consumer advocates have made Task Force members aware of the extent to which restraint and seclusion remobilize the trauma in abuse survivors. Client statements in the *DMH Core Curriculum on Alternatives to Restraint and Seclusion Training Manual* (November, 1993, pp 8,9) illustrate the traumatic impact that restraint may have on abuse survivors:

> "It is related by a client that once while in restraints, she was handled by males, and one of them pulled her pants and underwear down in preparation for a chemical restraint. 'I was terrified being touched by males,' she said. This was as a result of previous repeated abuse by a family member."
>
> "One client stated that as a child she was tied down and raped. Whenever she is placed in four-point restraint, it reminds

her of the incident, so that instead of getting in control, she becomes more out of control."

Many survivors have had personal experiences with abusers who had restrained them, forced drugs, and locked them away in closets, car trunks, and rooms, and invaded their privacy by watching them in bathrooms, showers, bedrooms, etc. Thus, something as routine to inpatient staff as turning the lights off in a child's room or a 15 minute room check at night may be viewed with intense fear by a trauma survivor. Through these accounts, we came to recognize that restraint and seclusion, although employed to de-escalate agitation and loss of control, often serve to worsen the situation because of their similarity to prior traumatic experiences. The *Final Recommendations on the Use of Restraint and Seclusion of the New York State Office of Mental Health* (June 1994) recognizes this when it states that the "potential negative impact of restraint and seclusion must be addressed in the decision to use these interventions, especially with patients who have a history of physical or sexual abuse." (Appendix 2)

The Task Force recommends that the Department of Mental Health take action to address this problem in the following areas:

I Assessment Procedures
II Use of Restraints
III DMH-DMA Draft Purchasing Specification
IV Emergency Services
V A Pilot Project for all-Women Units
VI Office of Internal Affairs
VII Training

I Assessment Procedures

Mental health professionals cannot develop appropriate treatment plans or interventions for clients in the absence of knowledge about their histories of physical or sexual abuse (MHM 1995). Clients should be asked about their history of sexual or physical abuse in all clinical settings. This would enable professionals to develop more effective treatment plans, provide more appropriate treatment, and allow the Department to begin to collect data to assist in planning for the development of future programs for its clients.

Trauma Assessment Form (Appendix 3)

The Task Force recommends the Trauma Assessment Form as a guide to gathering information with clients about a possible trauma history. It is

recommended for use as part of the intake assessment for DMH clients of all ages in all settings (inpatient, outpatient, emergency, crisis stabilization, day treatment, etc.). For children who are too young or unable to provide this history, much of the information can be gathered from parents or guardians. Other child assessment tools may be needed for very young children, such as anatomically correct dolls. The information obtained through the assessment should be used to develop the most effective and relevant treatment for the client.

Restraint Reduction Form (Appendix 4)

The Department's review of restraint and seclusion practices within each of its ten contracted inpatient facilities ("replacement units") found that several replacement units had a process to determine directly from the client, as part of the initial nursing assessment, what strategies had been effective to reduce or avoid the use of restraint and seclusion. The process was also used to help clients identify interventions that might further traumatize them. The replacement units using these processes found them helpful in reducing the use of restraint and seclusion and making restraint less traumatic. All replacement units indicated that such a process may be useful. (Crane and Weeks, 1995, p 3).

Building on this, the Task Force recommends the Restraint Reduction Form as a guide to gathering information with clients for the development of strategies to de-escalate agitation and distress. In this way, the use of restraint and seclusion can be decreased or eliminated. The form is recommended for use in conjunction with the Trauma Assessment Form in all acute care facilities, such as acute inpatient units, crisis stabilization and other diversion units, and psychiatric emergency rooms, when clinically indicated, namely, when the client has a history of loss of impulse control. Information about children can also be gathered from parents or guardians, who may have developed useful strategies for calming a very distressed or out of control child. The process of obtaining this information is the beginning of an important clinical intervention

II Use of Restraints

> An abuse survivor with a history of frequent hospitalizations was repeatedly restrained following episodes of agitation. She became more assaultive when she was approached by male staff. It was not until she was moved to an all-women's trauma unit that it was understood that these episodes represented terrifying flashbacks of the abusive experiences. On the acute psychiatric units, the abuse experience was actually re-enacted when male staff members forced her into restraints with legs spread apart just as her father had forcibly restrained her. In contrast, on the trauma

unit, a female staff member was able to talk her through the dissociative episode, gently reminding her that she was safe in the present and was experiencing intense and overwhelming psychological and "body" memories from the past. The client, curled up on the floor, was allowed to stay there while staff provided a soothing presence and a reality-based focus.

The precipitating event for the client's escalating distress was a flashback about her father's sexual abuse. In the first instance, the staff could not tolerate the client's sudden screaming, distress, and thrashing. Without a way of understanding her behavior, they responded to her behavior as a control issue. This lack of clinical understanding clearly escalated the client's distress to the point that she lost control. In the second instance, knowledge about severe trauma-related symptomatology in conjunction with the safety provided on an all-women's unit served to provide a therapeutic intervention rather than an experience of further damage. Understandably, freedom of movement, privacy, and control over one's body are of primary importance to all clients, and especially those who have been physically or sexually abused. In an environment designed to be healing and therapeutic, restraint is often experienced as abusive and confusing, in the same way that abuse in families is experienced as confusing (Rieker and Carmen, 1986; Carmen and Rieker, 1989).

Rape imagery permeates all of society, consequently, even those without a trauma history understand the symbolic meaning of the spread-eagle position. Because of the likelihood that restraints will retraumatize an abuse survivor, the Task Force emphasizes the importance of using the restraint reduction assessment to decrease the use of restraints. Several examples that might be considered less traumatizing are safety coats and papoose boards, among others, which should be more widely available in adult programs. Currently, these devices are used in children's secure treatment programs as containing options along with physical holds to de-escalate crises and reduce restraint use. It is often the case that a child (or adult) has been "held down" for a sexual assault so that certain "hands on" interventions are distinctly re-traumatizing. For other children, a firm but gentle physical hold may be all that is needed to de-escalate a situation. When appropriate, the safety coat or papoose board are the interventions selected for sexually abused children.

The staff member assigned to 1:1 with the client during and after the restraint should be a female or the opposite gender of the perpetrator(s) of abuse, unless the client has a different preference. Although both men and women can be abusers, sexual offenses against males and females are usually committed by males. Thus, it is critical to discuss gender preferences with clients as it relates to the aftermath of a restraint or 1:1. Finally, the need for client feedback is critical after a restraint episode, and clients should be asked for

feedback more than once, especially regarding what would have worked better to avert the restraint or to make the restraint less traumatic. The Department's "patient comment form" is intended to obtain this client feedback but is often used in a perfunctory way. Given age limitations, children and adolescents should be offered a less structured option for comment as found in the child and adolescent comment form.

Proposed Changes in DMH Restraint and Seclusion Regulations (Appendix 5)

As discussed above, the Task Force recommends the use of a Trauma Assessment Form and a Restraint Reduction Form as guides to gathering critical information necessary for the appropriate care and treatment of clients with a history of abuse. Facilities should have some discretion in deciding the precise wording of the forms and how they will be integrated into their assessment process.

The Task Force recommends that, as a matter of DMH policy, there should be a minimum requirement that each facility have a process to obtain information relevant to (i) history of abuse, (ii) de-escalation strategies that have worked and, (iii) what forms of restraint/seclusion are most helpful and least traumatic. We have therefore recommended that the DMH restraint/seclusion regulations be amended to include this minimum requirement.

Similarly, the Task Force concludes that there are several other minimum requirements that should be observed in order to minimize the potential of re-traumatizing persons with a history of abuse. These additional proposed changes to subsection 104 CMR 3.12(4) prevent the use of mechanical restraint requiring a patient's legs to be spread apart when the patient has a history of sexual abuse. Additions to subsection 104 CMR 3.12(9)(a) address the need, if a patient has a history of sexual abuse, for a staff person in attendance during restraint who is female or the opposite gender of the perpetrators of abuse, unless the patient requests otherwise.

III DMH-DMA Draft Purchasing Specification (Appendix 6)

The experience of our Task Force is that it is imperative for clinicians to routinely inquire about and understand the implications of a history of abuse in order for the mental health system to provide appropriate care and treatment to the many mental health consumers who are survivors of physical and/or sexual abuse. The suggested language additions are intended to highlight this concern:

Special Needs

The MCO shall develop clinical protocols with its specialized providers and DMH to address consumers with the following special needs: dually diagnosed (i.e. substance abuse and mental illness or mental retardation and mental illness), persons with a history of physical and/or sexual abuse, deaf and hearing impaired, elderly, chronically violent, etc.

The MCO shall ensure the availability of child-trained clinicians and clinicians with training and/or experience with elders in its Designated Emergency Programs (Emergency Program Standards) and the availability of clinicians with training and/or experience with clients who have a history of physical and/or sexual abuse.

Cultural Competence

The meaning of cultural competence should be extended to include an understanding of gender-specific needs as it relates to clinical treatment. The definition of safety as it is usually understood in a psychiatric treatment setting may be quite different and possibly at variance with the kind of safety necessary for the therapeutic care of women suffering from traumatic stress syndromes. For example, locked units are frequently contraindicated for women who have histories of being held captive and who were literally or figuratively "locked up."

Female clients may need the presence of a female staff member during an interview with a male clinician. A recent clinical example illustrates these concerns. A male psychiatrist on an acute inpatient unit insisted that a female client meet for an initial interview in her bedroom because no other private space was available. This aroused severe anxiety and terror in the client who immediately began to dissociate. Although she was able to refuse to meet alone in her bedroom with the psychiatrist, her ability to establish appropriate boundaries that would ensure her safety was misunderstood. She was labeled as manipulative and resistant to treatment.

Assessment and Treatment Planning

Assessments will include, at a minimum: the history of the psychiatric illness; past psychiatric history, past medical history, family and social histories, substance abuse history, history of physical and/or sexual abuse, mental status exam, present medications, diagnosis, treatment plan, and level of functioning.

Restraint and Seclusion in Emergency Programs

See Section IV

All-Women Units

See Section V

IV Emergency Services

Hospital Emergency Rooms

The Task Force heard of many consumer experiences in emergency rooms, in which clothing was removed routinely, significant others were not allowed to remain with the client, and restraints were used routinely, while the client waited in isolation for hours before being seen. Consumers who had been to emergency rooms on different occasions for either medical or mental health problems told us how differently they were treated, depending on whether they presented with medical or mental health problems. More humane treatment was usually afforded them when they presented for medical rather than psychiatric treatment. The potential for retraumatization is very likely when a client with a history of sexual abuse is asked to remove clothing by a clinician whom (s)he neither knows nor has reason to trust in an unfamiliar and chaotic public environment, thus leaving the client exposed and vulnerable. For the last two decades, rape crisis programs located in hospital emergency rooms have taken these issues into account in protocols designed to increase the victim's sense of control and safety while decreasing feelings of vulnerability and isolation. Psychiatric emergency programs have much to learn from rape crisis interventions.

The abuses of restraint and dehumanization in emergency room settings mandate that DMH regulations regarding restraint be extended to emergency settings through the use of regulation and contractual processes. In any case, there are no circumstances in which restraint or seclusion should be used routinely in an emergency service setting. The Task Force emphasizes that restraint or seclusion of a consumer may only occur when there is occurrence of bodily harm or where there is a serious, imminent threat of bodily harm and the present ability to effect such harm.

Community Crisis Stabilization Programs

DMH crisis stabilization programs are considered to be community programs, in which mechanical restraint is forbidden. The alternative has been physical containment by having one or more staff members physically holding the client. A client with a sexual abuse history would hardly be reassured by having several staff members lying on top of her or him for purposes of restraint. Because the nature of crisis stabilization units has changed in response to

public managed care expectations, many of these "community" programs have become mini-inpatient units in which acutely ill clients are kept for several weeks as the alternative to hospitalization. A trauma survivor who sought help through a community based crisis stabilization unit for self-injurious impulses reported that she would never go back there because "I felt like I was in an inpatient unit rather than in the community. I felt from the moment I arrived that I wouldn't be allowed to leave. I was terrified." The Task Force recommends that the Department review the role and function of its crisis services as these may have changed in the wake of decreasing inpatient resources. These changes raise particular issues for abuse survivors that warrant serious study.

V Pilot Project for all-Women Units (Appendix 7)

Many community programs are finding that women diagnosed with co-occurring mental illness, post-traumatic stress disorder, and substance abuse are over-represented among high users of emergency and inpatient services. Innovative programs that provide safer holding environments and specialized treatment to meet the needs these survivors may ultimately be more cost-effective. Appendix 7 outlines a pilot project proposal to establish single gender treatment and residential units and to evaluate whether such settings provide more effective and safer environments for the delivery of mental health services to women with concurrent mental illness and histories of abuse. The Task Force is aware that female (and some male) survivors are often unsafe in DMH inpatient, residential, and community programs where they may be victimized by predatory males, who themselves often have histories of victimization. Some of these assailants are other consumers and some are staff members. An unsafe environment can never be therapeutic.

There is considerable evidence that the needs and responses of this group of consumers may differ in some important ways from clients without an abuse history. Inadequately trained staff and lack of recognition of trauma sequelae (such as extensive needs for safety, compensatory substance abuse, self-injurious behaviors and loss of control of aggressive impulses toward others, etc.) can transform ordinary hospitalized interventions into a revictimization experience. For many women as well as female children and adolescents in crisis, the presence of men on treatment units may make the environment both threatening and nontherapeutic. Survivors often perceive and experience hospitalization procedures in the context of their abuse histories.

An all female secure 16-bed intensive residential treatment program for adolescents has been operating for six years. All adolescents referred to this program have histories of serious, repeated abuse. Although there are some male staff, intentionally hired to demonstrate that men can be safe and non-

abusive, they are never left alone with a female resident. This provides a more soothing, less threatening treatment environment for working through issues and relationships.

Program objectives are as follows:

1. To establish at least two statewide all women units to be included in the acute hospitalization service spectrum (DMA/DMH contract), with the goal of developing such units within each area's CCSS

2. To establish at least two all women residential units that would be located in the CCSS residential service program

3. To insure that the planning and evaluation of such therapeutic milieus include both specialists in the field of trauma and consumer survivor advocates

4. To create a safe environment in which survivors can deal with their anger

VI Office of Internal Affairs (Appendix 8)

The Task Force wrote to and subsequently met with Robert Baker, Director, Office of Internal Affairs. Since the Office of Internal Affairs is charged with investigating allegations involving sexual assault, abuse, intimidation, and harassment, the Task Force made the following recommendations for hiring and investigative practices in Internal Affairs:

1. The gender and cultural diversity of the investigators should accurately reflect the population being served.

2. The investigators should receive training in the psychological, physical, and behavioral consequences of sexual trauma. Additionally, for child and adolescent services, we recommend that only those investigators with training in children's mental health as well as knowledge of trauma in children be assigned to children's cases. We also recommend that ongoing training about the symptoms and experiences of children and adolescent trauma survivors be provided to such investigators.

3. Women who make allegations of sexual assault, abuse, intimidation and harassment should be interviewed by women investigators unless they request otherwise.

4. Interviews should take place in areas specified by the survivor

VII Training (Appendices 9-11)

All of the changes recommended in this report are contingent on the Department making a commitment to training staff about the extent to which survivors are represented among its priority clients, the psychological, medical, and behavioral consequences of abuse, and the spectrum of appropriate interventions.

There are many excellent training packages and materials that have been developed by clinicians and consumers. The best training opportunities will come from the collaboration between clinicians and consumers. The Department is fortunate in having rich resources among clinicians and consumers, who might be invited to put together training materials targeted at different audiences, for example, clinicians, direct care staff, administrators, et al. The Department's adolescent programs are much more aware of these issues than are adult programs. As an example, we have appended the *Policy and Procedure: Behavioral Interventions of the U Mass Adolescent Unit* (Appendix 9).

We have appended the *Implementation Strategy: Improving Services for Individuals Diagnosed with Serious Mental Illness who are Sexual Abuse Survivors* (New York State Office of Mental Health) (Appendix 10) to give some sense of how other public mental health systems are addressing this problem.

Finally we have appended *What Lies Ahead? Priorities for Change from the Dare to Vision Conference* (March 1995) (Appendix 11).

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Assessment of Abuse and Neglect

Standard

PE.1.15 Possible victims of abuse or neglect are identified using criteria developed by the organization.

Intent of PE.1.15

Victims of alleged or suspected abuse or neglect may be admitted to the organization through various settings or services. Appropriate care cannot be provided unless suspected or alleged victims are identified and assessed. Assessing the care needs of the individual is aided by using established criteria to identify possible victims of abuse throughout the organization. Maintaining a list of private and public community agencies that provide or arrange for assessment and care of abuse victims assists the organization in making appropriate referrals. The criteria address at least

- physical assault;
- rape or other sexual molestation;
- domestic abuse; and
- abuse of elders and children.

Example of Implementation for PE.1.15

If an adult presents to an urgent care service, and an explanation of his or her injuries does not seem to match the type of injuries he or she has (for example, X-rays show a broken bone), then the staff questions whether this is a case in which suspected abuse occurred.

Scoring for PE.1.15

Score 1 Documentation reflects that the organization has developed and implemented criteria to identify possible victims of abuse or neglect, that the staff is taught how to apply the criteria, and that the staff applies the criteria when appropriate.

Score 2 Documentation reflects that the organization has developed and implemented criteria and that the staff is how taught to apply them; however, the criteria address only three of the four elements listed in the intent.

Score 3 Documentation reflects that the organization has developed and implemented criteria; however, the staff is not taught how to apply them, or the criteria address only two of the four elements listed in the intent.

Score 4 Documentation reflects that the organization has developed criteria; however, they are not implemented.

Score 5 The organization has not developed criteria to identify possible victims of abuse or neglect.

Standards

PE.1.15.1 The assessment of victims of alleged or suspected abuse or neglect may be conducted by the organization's staff or referred to the appropriate setting.

PE.1.15.1.1 If the organization conducts the assessment, it

PE.1.15.1.1.1 is conducted with the consent of the individual, parent, or legal guardian, or as otherwise provided by law;

PE.1.15.1.1.2 is conducted in accordance with the organization's responsibility for the collection, retention, and safeguarding of evidentiary material released by the individual; and

PE.1.15.1.1.3 includes, as legally required, the notification of and release of information to the proper authorities.

Intent of PE.1.15.1 Through PE.1.15.1.1.3

Individuals who are possible victims of alleged or suspected abuse or neglect have special needs relative to the assessment or referral process. Information and evidentiary material(s) may be collected that could be used in future actions as part of the legal process. Therefore, the organization has specific and unique responsibilities for safeguarding such evidentiary material(s).

Documentation in the individual's clinical record needs to be consistent with organization policy and addresses the following items:

- Appropriate consents from the individual, parent, or legal guardian, or as otherwise provided by law, are documented in the individual's clinical record;
- Organization policy outlines the responsibility for collecting, retaining, and safeguarding evidentiary material released by the individual and appropriate documentation in the individual's clinical record; and
- Assessment activities include, as legally required, notification of and release of such information to the proper authorities.

Scoring for PE.1.15.1

Score 1 The organization has developed and implemented criteria to assess or refer possible victims of abuse.

Score 5 The organization has not developed and implemented criteria to assess or refer possible victims of abuse.

Scoring for PE.1.15.1.1

This standard is not scored.

Scoring for PE.1.15.1.1.1 Through PE.1.15.1.1.3

Note: *The following set of guidelines applies to each standard PE.1.15.1.1.1 through PE.1.15.1.1.3.*

Score 1 91% to 100% of reviewed clinical records of suspected or alleged victims of abuse or neglect reflect compliance with the standard.

Score 2 76% to 90% of reviewed clinical records of suspected or alleged victims of abuse or neglect reflect compliance with the standard.

Score 3 51% to 75% of reviewed clinical records of suspected or alleged victims of abuse or neglect reflect compliance with the standard.

Score 4 26% to 50% of reviewed clinical records of suspected or alleged victims of abuse or neglect reflect compliance with the standard.

Score 5 Fewer than 26% of reviewed clinical records of suspected or alleged victims of abuse or neglect reflect compliance with the standard.

Appendix 3

Task Force Concerned with Restraint/Seclusion of Persons who have been Physically and/or Sexually Abused
Trauma Assessment for DMH Facilities/Vendors

This form is a guide to gathering information with clients about a possible trauma history. It is recommended for use as part of the intake assessment for all DMH clients in all settings (inpatient, outpatient, emergency/ crisis, day treatment, etc.). In acute care settings, it should be used in conjunction with the Restraint Reduction Form. The information obtained should be incorporated into the client's treatment plan.

1. Does client have a history of physical abuse (e.g., hit , punched, slapped, kicked, strangled, burned, threatened with object or weapon, etc.)? Yes___ No___ Don't Know ___

If yes, in childhood? ___ adolescence? ___ adulthood? ___ at present? ___

By whom? stranger ___ acquaintance ___ partner/spouse ___ parents ___

other family member ___ ritual abuse ___

2. Does client have a history of sexual abuse (e.g., unwanted kissing, hugging, touching, nudity, attempted or completed intercourse)? Yes___ No___ Don't Know ___

If yes, in childhood? ___ adolescence? ___ adulthood? ___ at present? ___

By whom? stranger ___ acquaintance ___ partner/spouse ___ parents ___

other family member ___

3. Has client ever been raped? Yes___ No___ Don't Know ___

If yes, in childhood? ___ adolescence? ___ adulthood? ___ recently? ___

By whom? stranger ___ acquaintance ___ partner/spouse ___ parents ___

other family member ___ ritual abuse ___

4. Has client experienced an acute trauma such as a natural disaster, severe accident or threat to life, witnessing a death or violence to someone else, or been a victim of a crime?
Yes__ No __ Don't Know ___
If yes, at what age and circumstances? _____
_____

5. If yes to any of the above, is client experiencing flashbacks, nightmares, insomnia, numbness, confusion, memory loss, self injury, extreme fearfulness or terror, etc., related to the trauma? Yes ___ No___
If yes describe _____
_____
_____

Please incorporate the information obtained in the trauma assessment into the treatment plan for this client.

Appendix 4

Task Force Concerned with Restraint/Seclusion of Persons who have been Physically and/or Sexually Abused
Restraint Reduction Form for DMH Facilities/Vendors

This form is a guide to gathering information with clients for the development of strategies to de-escalate agitation and distress so that restraint and seclusion can be averted. It should be used in conjunction with the Trauma Assessment Form. It is recommended for use in all acute care facilities, such as acute inpatient units, crisis stabilization and other diversion units, and psychiatric emergency rooms, when clinically indicated. Indications include a past history or likelihood of loss of control of aggressive impulses. The information obtained should be incorporated into the treatment plan for this client.

1. It is helpful for us to be aware of the things that can help you feel better when you're having a hard time. Have any of the following ever worked for you? We may not be able to offer all these alternatives but I'd like us to work together to figure out how we can best help you while you're here.

voluntary time out in your room		listening to music	
voluntary time out in quiet room		reading a newspaper/book	
sitting by the nurses station		watching TV	
talking with another consumer		pacing the halls	
talking with staff		calling a friend	
having your hand held		calling your therapist	
having a hug		pounding some clay	
punching a pillow		exercise	
writing in a diary/journal		using ice on your body	
deep breathing exercises		putting hands under cold water	
going for a walk with staff		lying down with cold facecloth	
taking a hot shower		other? (please list)	
wrapping up in a blanket			

2. Is there a person who has been helpful to you when you're upset? (Y/N) Would you like them to come and visit you? (Y/N) Can we assist in this process? (Y/N)
If you are in a position where you are not able to give us information to further your treatment, do we have your permission to call and speak to _____(name) _____(phone)? (Y/N) If you agree that we can call to get information, sign below:
Client signature _____ Witness _____ Date _____

3. What are some of the things that make it more difficult for you when you're already upset? Are there particular "triggers" that you know will cause you to escalate?

being touched		being isolated	
bedroom door open		people in uniform	
particular time of day (when?)		time of the year (when?)	
loud noise		yelling	
not having control/input (explain)		other (please list)	

4. Have you ever been restrained in a hospital or other setting, for example, in a crisis stabilization unit or at home?

	physically/mechanically?	chemically?
when?		
where?		
what happened?		

5. If you are escalating or in danger of hurting yourself or someone else, we may need to use a physical, mechanical or chemical restraint. We may not be able to offer you all of these alternatives, but if it becomes necessary, we'd like to know your preferences.

quiet room	seclusion	
physical hold	safety coat	papoose board
3-point restraint	face up?	face down?
4- point restraint with legs together	face up?	face down?
chemical restraint		

6. Do you have a preference regarding the gender of staff assigned to you during and immediately after a restraint? Women staff ____ Men staff ____ No preference ____

7. Is there anything that would be helpful to you during a restraint? Please describe.

_____

_____

8. We may be required to administer medication if physical restraints aren't calming you down. In this case, we would like to know what medications have been especially helpful to you? Please describe.

_____

_____

9. IF FACILITY DOES ROOM CHECKS: We do room checks here to make sure you are okay at night. We are trying to make these room checks as nonintrusive as possible. Is there anything that would make room checks more comfortable for you?

_____

_____

Please incorporate the information obtained in the restraint reduction form into the treatment plan for this client

Proposed Changes in DMH Restraint and Seclusion Regulations

In subsection 104 CMR 3.12(4), add the following new paragraphs at the end:

(h) Assessment of Patient. As part of a facility's intake assessment process, staff shall seek to determine from each patient, from the patient's record and, where necessary, from other treating clinicians

(1) whether the patient has a history of being physically or sexually abused,
(2) what particular approaches or strategies will be most helpful to the patient in order to avoid needing to use restraint or seclusion,
(3) what kind of restraint or seclusion, if needed, would be most helpful and least traumatic for the patient, and
(4) the gender of staff, if available, who should administer and monitor restraint or seclusion, if used.

(i) Restraint of Persons with a History of Sexual Abuse. No mechanical restraint requiring the patient's legs to be spread apart may be used on a patient with a history of sexual abuse.

(j) Patients who are Menstruating. A patient who is menstruating shall be given the opportunity to apply to herself fresh pads or tampons at least every 2 hours unless the patient is a violent threat to herself or others.

(k) Observation of a Clock. Patients in restraint shall be able to observe continually a functioning clock.

In subsection 104 CMR 3.12(9)(a), add the following new paragraphs at the end:

6. If the patient has a history of sexual abuse, the staff person(s) in attendance during restraint shall be female or the opposite gender of the perpetrator(s) of abuse, unless the patient requests otherwise. In an emergency situation when a staff person of the appropriate gender is not available, staff of a different gender may be in attendance. In this case the superintendent, director of the facility or authorized physician shall, within 24 hours of the restraint incident, attach to the restraint form a written report as to why a staff person of the appropriate gender was not in attendance.

7. No staff person who has been the subject of a substantiated or pending complaint of sexual molestation, harassment or abuse may be in attendance of a patient who is in restraint or seclusion or on one-to-one staffing.